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adult children of alcoholics describing their parents' drinking problems**

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Understanding Addiction: Adult Children of Alcoholics Describing Their Parents' Drinking Problems

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Abstract

Based on qualitative interviews with adult children of alcoholics, this article analyzes three different ways of conceptualizing drinking problems: alcoholism as disease, alcoholism as volitional behavior, and alcoholism as a socially conditioned phenomenon. The interviewees (13 women, 12 men, average age 39 years) were recruited among employees at a large workplace who in a preceding survey had classified their parents as having “alcohol problems.” The analysis reveals a pattern in which adult children’s understandings of their parents’ drinking problems, in essence the ways they think alcoholism should be explained, are associated with the ways they describe their relationship to their parents and the hardships of their childhood. The article suggests that differences in childhood experiences may lead to different ways of understanding the phenomenon of alcoholism, just like differences in understandings of alcoholism may affect recollections of childhood experiences.

Keywords

children of alcoholics, understandings of alcoholism, qualitative interviews, narratives

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Introduction

This article analyzes the understandings of addiction among adults who have grown up in families where the father or mother, or both parents, were problem drinkers. Based on qualitative interviews, it describes variations in how adult children of alcoholics (ACOAs) conceptualize their parents' alcohol problems and how they assess the consequences of these problems. The article focuses on the participants' understandings of alcoholism as being a "disease," "volitional behavior," or a "socially conditioned phenomenon" and analyzes how these conceptions are related to the character of the child–parent relationship, as this is described in the interviews.

Growing up with an alcoholic parent is a widespread phenomenon. In Denmark, which provides the context of the present study, the proportion of children growing up in families with alcohol problems has been assessed as 11% to 12% (Kristiansen, Ekholm, Grønbæk, & Tolstrup, 2008). There is an extensive body of research analyzing the negative consequences of living with an alcoholic parent; for reviews of this literature, see Giglio and Kaufman (1990), Windle and Searles (1990), Sher (1992), Velleman and Orford (1999), and Harter (2000). Compared with the myriad of quantitative studies on children of alcoholics the paucity of qualitative research is striking. Reviewers of the literature typically mention a handful of qualitative studies, stating that the voices of children of alcoholics are seldom heard.

Kroll's (2004) analysis of some of the qualitative studies in the field shows two things. First, that most of them are based on clinical samples. Researchers have either interviewed alcoholics' children when they were young and accompanied their parents in treatment programs or as grown-ups receiving treatment for their own substance use or mental health problems. Second, these studies tend to depict a rather homogenous portrait of the hardships of growing up with an alcoholic parent: denial and secrecy, separation and loss, family breakdown and conflict, violence, abuse, and fear (Kroll, 2004; Laybourn, Brown, & Hill, 1996; Moe, Johnson, & Wade, 2007; Velleman & Orford, 1999). Researchers typically focus on the difficulties of alcoholics' children both while they live with their parents and when they are adults, encouraging professionals to prevent maladjustment by intervening in the families of alcoholics as early as possible (for a critical discussion of this literature, see Burk & Sher, 1988).

One of the exceptions from this qualitative tradition of presenting homogenous portraits of children of alcoholics is Haugland's (2006) qualitative study. Haugland explicitly focused on the variations in how parental drinking problems affect family life. She distinguished between different types of families showing that some parents are able to protect their children against

disruptions, insecurity, and chaos despite serious drinking problems. The sample in Haugland's study contained very different family profiles ranging from "protecting families" where the drinking caused minor changes in rituals and routines to "chaotic families" where children were exposed to destructive drinking patterns, violence, and lack of parental responsibility.

The present study contributes to the limited tradition of qualitative research on children of alcoholics, focusing on differences between ACOAs' childhood experiences rather than painting a homogeneous picture of the hardships of growing up with alcoholic parents. The aim of the article is to analyze ACOAs' understandings of alcoholism and their depictions of parent-child relationships. Based on previous research, I expect some variants of drinking problems (recounted in the interviews) to be associated with poorer parent-child relationships than others. However, unlike previous research, I analyze this as a two-way relationship, in which parent-child relationships affect conceptions of drinking problems, just like conceptions of drinking problems affect recollections of parent-child relationships. Furthermore, this is a narrative study based on ACOAs' retrospective accounts about their childhood experiences, and not on objective measures of alcoholism and its consequences for children's welfare. Participants describe their parents' problems in varying ways, but typically with reference to one of the dominant approaches to alcoholism mentioned above. There is a pattern in the interviews tying certain understandings of alcoholism to certain descriptions of parent-child relationships. Furthermore, the interviews indicate that participants' perceptions of their parents' drinking problems may also be related to their own drinking habits as grown-ups.

As opposed to most previous studies in the field, this is a sociological study based on a nonclinical sample of adult children of alcoholics. The sample, consisting of 25 interviewees, was recruited among employees at a large workplace who in a preceding survey had classified their parents as having "alcohol problems." This means that it is the interviewees themselves, and not the researcher or professionals in the treatment system, or the parents themselves for that matter, who have defined the drinking patterns in question as problematic.

Before describing the data and methods of the study, I present the theoretical framework used to analyze the interviewees' accounts on alcoholism: alcoholism as disease, alcoholism as volitional behavior, and alcoholism as a socially conditioned phenomenon.

Approaches to Alcoholism

"Addiction as disease" is in many Western countries the dominant way of understanding alcoholism, in the treatment system, among individuals who

see themselves as being in recovery from it, and among people in general (Reinarman, 2005). Yet as Levine (1978), Room (1983, 1984), and others have convincingly shown, “addiction as disease” (and “addiction” in and of itself) is a historical creation of a particular epoch and in a specific cultural location. Levine (1978) describes addiction as a modern invention, emerging in the late 18th and early 19th centuries. Before the era of industrialization, Levine says, drunkards were supposed to have a will and a capacity to make choices; they were not yet associated with the phenomenon of addiction, which later would deprive heavy consumers of their volition. Gradually, however, the disease concept of addiction created a definite boundary between “alcoholic” drinking and “normal” drinking. The amount of alcohol consumed was not seen as decisive for whether the drinking was alcoholic or normal; instead, the crucial marker was the experience of “loss of control” (Room, 1984, p. 175). According to Davies (1992), the disease concept of alcoholism became popular not necessarily because it fits with the observable facts about habitual, heavy drinking, but because it serves useful purposes. The concept is a “functional attribution,” a means for absolving blame and moral censure. Addiction as disease translates behavior that could otherwise be seen as “bad” and “purposive” into behavior that is “non-volitional” and hence “non-culpable” (Davies, 1992, p. 270). The concept of addiction is a “discursive device” through which the drinker and his/her surroundings can account for untoward behaviors (May, 2001, p. 393). Addiction as disease articulates a subordination of personal agency to an unwilling mechanism that the drinker cannot control (Reith, 2004). It is no longer the drinker who acts; it is addiction that acts on behalf of the drinker.

Although the disease concept has been, and probably still is, dominant in contemporary understandings of alcoholism, it does not stand alone. One of the analytical alternatives to the disease model is the “voluntaristic” perspective on addiction. According to this perspective, addicts do not lose control over their behavior in the way the disease model presupposes. Skog (2000, p. 1310) points out that there is a “conceptual asymmetry” in the disease model: the decision not to drink is called control, whereas the decision to drink is called lack of control. According to Skog, there is no reason to believe that the drinker is choosing when one set of motives are dominant, and not choosing when the order is reversed. Furthermore, “To claim that an individual is unable to choose is a very radical view—it reduces this individual to something less than a full person” (Skog, 2000, p. 1309). In contrast, the starting point for the voluntaristic perspective is that people act in accordance with their preferences (appetites, interests, commitments). Heavy drinkers, just like other choosing and acting subjects, evaluate alternative options, select the best alternative (according to their preferences), and act. At the core of the

voluntaristic model of alcoholism is the idea that addiction represents a “motivational conflict” in the drinker: the alcoholic both wants to drink and does not want to drink (Skog, 2000, p. 1310). If the appetite for continued consumption becomes strong enough, and the opposing motives can no longer hold the person back, he or she drinks, and this decision is no less volitional than if the person had decided not to drink. Thus, addicts cannot be said to act contrary to their own will, because at the moment of choice, their actions are in accordance with their preferences (Skog, 2000).

The third model of alcoholism that is relevant for the interpretation of the findings in the present study is the sociocultural model. Room (1985, p. 134) describes this as a model accentuating aspects of dependence “seated at group or cultural levels, rather than at psychic or physical levels.” The sociocultural perspective on alcoholism focuses on social mechanisms that can create and sustain alcoholic behavior even in the absence of an individually experienced physical or psychological dependence (Room, 1985). Weinberg (2002) presents a “praxiological” model of addiction, which also includes the dimension of embodied habits. Applied to addiction, this perspective suggests that “the meaning of [alcohol] and the emotional effects it has on us derive to a significant extent from the ways in which we have come to use [alcohol] in the various social contexts that make up our lives” (p. 15). Addiction may be understood as a “more or less self-actuating tendency” to engage in a socially acquired form of action (here: heavy drinking; Camic, 1986, p. 1044). Thus, the praxiological perspective on addiction is an alternative to the voluntaristic model of cognition and decision making, because it regards addictive drinking as a form of practice that is not (necessarily) subject to reflexivity. It is also an alternative to the disease model because it comprehends addiction not as driven by ungovernable physical impulses or by “a disease of the will” (Valverde, 1998), but as an expression of a socioculturally embedded but individually embodied habit of heavy drinking.

Data and Method

The study is an off-shoot of a larger research project on alcohol consumption among the employees in a middle-sized Danish company occupied with research, development, marketing, sales, and distribution. A survey¹ among these (around 2,000) employees revealed that 10% had grown up with parents who had alcohol problems. The respondents answered the following question about their parents’ drinking: “How much alcohol did your parents normally consume on weekdays when you were around the age of 15?” The alternatives were the following: “they did not drink at all,” “they drank on rare occasions,” “they drank a couple of times a week,” “they drank a little

every day, such as a glass of wine at dinner,” “they often drank until drunk,” “they had problems with alcohol,” and “I cannot remember.”²²

All survey respondents were asked if they were willing to participate in a subsequent qualitative interview focusing on the same themes as the survey. Of the respondents saying that their parents had drinking problems, about half agreed to an interview (this proportion was a little higher than in the survey as a whole, where 45% agreed to participate in a subsequent qualitative interview). Based on information about all ACOAs in the survey, a sample was created, consisting of respondents who were as representative as possible (in terms of gender, age, socioeconomic background, and their own drinking pattern) of the whole group. In three cases it was impossible to make arrangements for an interview (because the respondents were abroad or on vacation)—these respondents were replaced by other participants with a similar profile, so that the final sample consisted of 25 persons.

Of the 25 interviewees, 13 were women and 12 men, and the average age was 39 years. The educational distribution of the sample was as follows: primary school, or primary school supplemented by vocational courses, 8 people; 2 to 4 years of college, 9 people; postgraduate training, 8 people. As for the participants' childhood families, four grew up in families where one or both parents had a postgraduate training, eight in homes where the parents had 2 to 4 years of college training, and eight came from working-class homes; information was missing for five people. Growing up with an alcoholic father and a normally drinking or nondrinking mother was more common (14 interviewees) than growing up with an alcoholic mother and a normally drinking father (five interviewees), whereas six said that both their parents were alcoholics. About half of the interviewees (12 people) reported that their alcoholic parents were now dead. Among the alcoholic parents who were still alive (in all 15 people), three had stopped drinking completely, according to their adult children, six continued to drink heavily, and three drank moderately (information missing for three people).

The interviews addressed the following broad themes: parents' drinking patterns (regular drinking vs. heavy episodic drinking, amount and type of alcohol consumed, drinking contexts, etc.), consequences of parents' drinking, description of parent-child relationship, understanding of alcoholism and addiction (question: “What is alcoholism?”), interviewees' own drinking history, and present drinking patterns.

The participants were interviewed at their workplace or at the researcher's workplace. The interviews lasted from 50 to 95 minutes, with an average of 75 minutes. All interviews were recorded and later fully transcribed. In the quotes from the interviews, all information that could jeopardize the anonymity of the respondents has been changed or omitted.

Analysis

When reading the interviews it quickly became clear that the participants represented different understandings of drinking problems. These differences were visible in their answers to the question “What is alcoholism?” in the interview guide, and in their elaborations on this theme, inspired by follow-up questions such as “What is the difference between alcohol use and alcohol abuse?” “What is addiction?” and “What are the main reasons for the development of drinking problems?” A preliminary analysis, based on open coding of the interviews, and especially of the interviewees’ answers to the above-mentioned questions, identified the three approaches to alcoholism described above: alcoholism as disease, alcoholism as volitional behavior, and alcoholism as a socially conditioned phenomenon.

The preliminary analysis was used to generate a set of themes and key phrases according to which the data could be sorted and synthesized in Nvivo. Examples of key phrases relevant for the three approaches to drinking problems were “illness,” “disease,” “craving,” “control loss”; “volitional,” “choice,” “will-power”; and “social drinking,” “drinking culture,” “workplace drinking.” In this way, the preliminary categorization of the interviewees into three groups—based on their answers to the question “What is alcoholism?”—could be checked against the contents of the interviews as a whole. Among other analyses, a simple Nvivo text search query was conducted, searching for the above-mentioned key words (and synonyms) in individual interviews. This resulted in a recategorization of two participants: one was moved from the “social explanations group” to the “illness group” (she referred to drinking culture in her answer to the question about alcoholism, but her interview was filled with accounts identifying alcoholism as a disease) and one was moved in the opposite direction. As a final step in this part of the analysis, all interviews were read again in order to secure that the key words used were indeed associated with the specific approaches they were thought to represent.

Matrix coding queries were then used to create tables that compared the three groups in the data. The focus in this part of the analysis was on participants’ descriptions of their relationship to their drinking parent(s), in terms of closeness versus distance, identification versus nonidentification, and expressions of emotion (e.g., pity, repulsion, anger, solicitude). Also, the participants’ descriptions of their own drinking were included in the comparisons between the three groups. In these parts of the analysis as well, Nvivo queries were combined with contextual reading of the interviewees’ accounts.

In the sections that follow, I analyze the interviews narratively, meaning that I do not regard the participants’ accounts of their childhood as the “objective truth” about growing up with an alcoholic parent, but rather as their way

of creating meaning of and coming to terms with this experience. Life histories, in a narrative perspective, are always “knowledge in the making,” an ongoing interpretative accomplishment in which interviewees struggle to discern and designate the recognizable and orderly parameters of experience, combining different meaning-making horizons of their life (Holstein & Gubrium, 1995, Järvinen, 2004). In Ricoeur’s (1984) words, “Narrative answers the question why at the same time as it answers the question what” (p. 152). To narrate one’s life is always (and by necessity) a selective affair of grouping some elements together into causal patterns and leaving other elements out as lacking relevance (Järvinen, 2000, 2001). The life events of our past are not demarcated units hoarded up in a container of experience, ready for the researcher, or the narrator himself/herself to gather (Mead, 1959). The initiative in narrated life history does not belong to the past alone but also to the interpretative framework used in the recollection. And this interpretative framework is not created by the individual narrator alone; it always contains building-blocks from already existing understandings, that is, from cultural scripts stipulating how happenings, fortunate as well as unfortunate, should be interpreted (Järvinen, 2000, 2004).

As mentioned above, the participants were divided into three main groups in accordance with how they related to their parents’ drinking problems: one group who predominantly regarded alcoholism as a disease (eight people), one group predominantly seeing alcoholism as volitional behavior (six people), and one seeing it as socially conditioned behavior (eight people). This categorization was possible for all except for two persons who either combined equal shares from two approaches or did not relate to any of the approaches.

I analyze the three approaches to alcoholism one by one, showing how they are related to the interviewees’ narratives on childhoods (unhappy childhoods, happy childhoods, or something in between) and parent–child relationships. Later on, I return to the question of how the association between alcoholism models, description of parent–child relationships, and (partly) the interviewees’ own drinking as grown-ups may be interpreted.

Alcoholism as Disease

The first group of interviewees regarded their parents’ alcoholism as a disease. Sophie (34), a technician, grew up with an alcoholic father. She said the following about alcoholism:

It’s a disease. In my view it’s not people’s own fault if they become alcoholics. It’s their own responsibility to do something about it. But nobody chooses to become an alcoholic, just like nobody chooses to get cancer or depression.

Sophie came from a middle-class family living in a “typical suburban neighborhood.” When she was a teenager, her parents got divorced because her mother “was unfaithful and moved in with another man.” Sophie chose to live with her father, “out of solidarity with him.” She said she always felt sorry for him “because he has really done his best to take care of me, there was always food on the table.” Shortly after the divorce, her father met a new woman, who also “became mixed up in his boozing” and things got worse. Sophie moved out to live on her own when she was 17 because she could not stand it at home anymore. When she was 25, her father stopped drinking “from one day to the next” because his doctor told him he would die in 3 months if he continued. At the time of the interview, he had started to drink wine again, but not to the extent that he used to. Sophie said that very few people know that she grew up with a father who “always needed alcohol first thing in the morning because his whole body was shaking.” To the question as to why she had never mentioned her father’s alcoholism to friends or colleagues, she answered:

Because there is a lot of prejudice against alcoholics. If you tell people your dad is an alcoholic, they right away denounce him instead of seeing him as the person he is. I don’t tell my friends about my dad’s problems because I know they would think I am one of those who have been mistreated at home. And it hasn’t been like that for me. (Sophie, 34)

Yet Sophie also said that she had suffered a lot from her father’s drinking and that “hidden alcoholism” may be harder for children to handle than “open alcoholism.” “We always had to hide it and keep up appearances. It’s probably easier if everybody knows your dad drinks.” She has been in therapy many times, she said, “because children of alcoholics often sink into a black hole.” She had never told her father about the problems his drinking has caused her: “He doesn’t know that I have been in all these therapy groups in order to deal with his drinking. It’s the old thing about protecting your parents.” Sophie herself drank very little because she had “seen all the bad sides of alcohol” and because “alcoholism is hereditary.” She said that children of alcoholics react differently to alcohol than other people; they can take a lot of alcohol, they do not suffer from hangovers, their body “recognizes the effects of alcohol immediately and wants more and more of it.” She had therefore decided to be “extremely careful” with alcohol.

Linda (54), an economist, is another example of interviewees seeing their parents’ alcoholism as an illness. Or rather, she regarded her mother’s alcoholism as an illness and her father’s as resulting from “bad company” and “bad habits.” “My mother was sick, she was genetically disposed to develop

dependence. . . . My father was just a heavy, social drinker with a screwed-up relationship to alcohol.” Linda grew up in a middle-class family with violence, “psychological maltreatment” (from both her parents), sexual abuse (committed by a person outside of her family), and “denial” of alcohol and other problems. She said she was the scapegoat of the family; that her parents often told her their problems were her fault and that she “always did her utmost to mediate and help them handle their problems” because “she has been able to understand them both, from her early childhood on.” She described her parents as hard and unloving but yet said the following about her mother:

My mother and I had a very close relationship. I always was there for her and she had taught me from very early on that she was the only person who could ever love me. We were very close until she died and her death was a hard blow for me. (Linda, 54)

Linda said it was only after her mother’s death that she came to realize how one-sided their relationship was. Already when she was 16, she took it on herself to help her mother solve her alcohol problems. She took her to a treatment center, sat in the waiting-room while her mother talked with a psychiatrist, and enjoined her to take her Antabuse every day: “It’s absolutely insane. You should never take on responsibility for an alcoholic’s behavior, at least not when you are 16 years old” (Linda, 54).

Most interviewees who described their parents’ alcoholism as a disease had been in contact with the addiction treatment system, either as children or teenagers getting involved in their parents’ treatment or as adults participating in therapy sessions or AA activities for family members. Two interviewees explicitly said that this has “helped them realize” that their heavily drinking parents were indeed ill, and therefore, that they “could not be blamed for what they did to their children” (quote from interview). One interviewee said that she did not see her alcoholic mother for 15 years but that she then, after having been involved in Al-Anon for a couple of years, reestablished her relationship with her: “I started to ask myself what kind of responsibilities I have in relation to her. Should I take on that responsibility? Should I be a helper?” (Merete, 46, secretary). The interviewee said that her two siblings did not agree that alcoholism is a disease: “They feel our mother has let them down and don’t want anything to do with her.”

Almost all interviewees who subscribed to the disease model said they were in contact with their alcoholic parents (if the parents were still alive). Some of the parents continued to drink heavily, others drank moderately now; this last alternative, however, did not make the interviewees refrain

from the disease model's belief in the incurability of addiction. They still assented to the idea "once an alcoholic, always an alcoholic" and said they feared that their alcoholic parents would sooner or later "fall in again."

Alcoholism as Volitional Behavior

Interviewees who regarded addiction as "volitional behavior" described a distinctly different relationship to their parents than the interviewees above. They tended to speak about their parents in negative terms and many of them said they had broken off contact with them, either for short periods or permanently. They felt that their parents had let them down, by "choosing alcohol in preference to their children" (expression used in interview), and said that they owed them nothing. Some interviewees in this group criticized the disease model of addiction for freeing the drinker of responsibility. Two interviewees explicitly said that children should never be "parents for their alcoholic parents," either when they are young or as adults. Other interviews in this group contained elements of the disease model and/or the social model (to be analyzed below) alongside the volitional model, showing that the distinctions between the three models are not absolute.

One of the participants in the volitional group was Mathilde (32), a technician. Asked to describe "what alcoholism is," she answered that it is the consequence of a person's "bad choices" in life:

After all, you choose how you want to live your life when you are a grown-up, don't you? They [Mathilde's parents] chose to enter this road in the first place and they had a choice to change their behavior every single day, but they didn't. (Mathilde, 32)

Mathilde's father was a carpenter with "severe alcohol problems"; "my first memory of him is: terribly drunk, always an alcoholic, started to drink first thing in the morning." Mathilde said she knew all the pubs in the neighborhood, because she often accompanied her father to them when she was a child. She said this about her mother: "She drank with dad, tried to smooth things out in the 'nothing wrong with us' way; she always tried to conceal it. Our home was boxed-off, isolated from other people, a place absolutely unfit for children." Mathilde described her childhood and adolescence as "18 years in hell" and said her parents never showed her any affection but rather subjected her to "psychological abuse." The home was well-kept, her parents attended to their jobs, and nobody (relatives, friends, neighbors, school teachers, etc.) intervened, probably because "they did not know how devastating my situation was, if only they had known they would have removed me

immediately.” When Mathilde was 17 or 18, she moved away from her childhood home and at the time of the interview she had not seen her parents in 10 years. She said the following about her relationship to them:

I always felt that my life could not begin before I got away from them. . . . You often hear about children [of alcoholics] who are deeply attached to their parents . . . and who are very loyal to them. Well, I wasn’t and I think that was my force. If we had had a good relationship, or a normal affectionate relationship, it would probably have been harder for me [to leave them]. If there had been something good to look back on—but there was nothing. It was always awful. (Mathilde, 32)

Mathilde was proud of the fact that she has not become an alcoholic herself, and that she had got an education and a good job: “It was on the cards that my life should go down the drain too, wasn’t it, but it didn’t.” She almost never thinks about her parents, she said, and she did not even know if they were dead or alive.

Another example of interviewees who regarded alcoholism as resulting from “personal choices” was Christoffer (35), a scientist. Christoffer answered the question “what is alcoholism” in this way:

Alcoholism always emanates from the person himself or herself. Nobody forces alcohol down your throat. . . . My dad could have chosen differently but he didn’t. I never felt a wish to regulate his behavior, I never even tried and I don’t think other people should try either. It was all up to him. He made too many stupid choices, and he lived and died with these choices. (Christoffer, 35)

Christoffer said his father was “heavily addicted” and that he had developed a tolerance for alcohol, which meant one could not necessarily see how drunk he was: “I discussed this with my mom afterwards and she said our doctor once confirmed that my dad could drink 24 beers and yet he didn’t seem drunk.” Christoffer also said: “My dad was never unpleasant or violent. I don’t hate him, I never did, I just think he was a very pathetic person.” After the parents’ divorce, when Christoffer was 18, his father’s life went “steeply downhill” and Christoffer had very little contact with him:

It wasn’t natural for me to look after him, to help him find a place to live, arrange for him to get something to eat, or try to make him stop drinking. I realized very early on that this wasn’t my responsibility at all and I stuck to this decision until he died. It’s not natural to start being a parent for your own parents; it makes you give up your own life. . . . I always felt I owed him nothing. (Christoffer, 35)

Interviewees in this group also assessed their own behavior from the point of view of the volitional model. They depicted themselves as different from their drinking parents, in terms of lifestyle, relationships to other people, career, and drinking patterns, and ascribed this difference to deliberate decisions, “will-power,” or “backbone.” Some mentioned a specific moment in their life, typically in their late teens or early 20s when they “made up their mind” never to become like their parents. Nina (43), an administrator, said,

It was a very deliberate decision on my part. I decided that I would never walk around in an eternal alcohol fog like my father. I had to make up my mind very early: do I want to follow this Pavlovian learning law and end up like my parents, or do I want to decide things for myself, and I chose the second alternative. (Nina, 43)

Alcoholism: A Socially Conditioned Phenomenon

Participants in the third group were of the opinion that alcoholism can be explained by social factors such as a “wet” drinking culture at certain workplaces or in a circle of friends and acquaintances. Alcoholism is, according to these interviewees, a “bad habit” that a person gradually develops together with other people who have similar drinking patterns. Some participants in this category explicitly rejected the idea that alcoholism is a self-elected condition. Heavy drinkers do not “choose” to drink too much, they said, they merely drink like the others in their social environment, until they one day are “trapped” in their drinking habits. A couple of interviewees also rejected the idea of alcoholism as a disease. You do not have to be genetically disposed to become an alcoholic, they reasoned. Anyone can become addicted if they drink enough and for long enough. Alcoholism is a “normal” reaction to social drinking habits that have gradually become “abnormal,” as one of the interviewees put it. Other participants in this group stated that there may be elements of deliberation or illness in the development of alcohol problems in their parents, but that these are of minor relevance compared with the social factors involved.

Monika (39), an assistant, said, “I grew up in a community where it was absolutely normal to be an alcoholic. All the men were workers and it was only the religious ones who weren’t alcoholics.” She described the background of her father’s alcoholism:

I think it sneaked up on him gradually. My dad was a carpenter and the first thing you learned back then as an apprentice was to go and fetch a beer for your master. It was a culture where you drank beer in the morning, at lunch, in the

afternoon . . . just like we nowadays walk around with a bottle of spring water. And if you go on drinking beer like that for a while, you become dependent. (Monika, 39)

To the question as to whether her father was dependent on alcohol, Monika said:

Definitely. If you *have* to drink first thing in the morning in order to be able to get out of your bed, you are dependent. It was half a bottle of aquavit and 12 beers every day, just in order to function.

When Monika was 14, her parents got divorced. She said the following about her relationship to her father: "I kept on seeing him until he died. I never doubted that he loved me. He just couldn't find the right way to express it." Monika did not think that alcoholics are different from other people: "I think people who are dependent on alcohol may be just as strong-minded and mentally sound as others. . . . It's a matter of chance and in what direction you're pushed by your surroundings."

Marco (30), a skilled worker and son of a shopkeeper, described his parents' drinking in a similar way:

My dad used to be an alcoholic and my mom drank a lot too but she was not dependent. . . . Heavy drinking was very normal in their circle back then in the 80s and 90s . . . and my dad simply became dependent little by little. . . . I mean, when you reach the stage where you need a beer in the morning to wake up properly, that's dependence. (Marco, 30)

Five years ago Marco's father went into treatment for his alcohol problems and somewhat surprisingly Marco said this was a pity:

It was a bit annoying because I thought I would lose some of the things we had together. . . . During my teenage years I sometimes drank beer with him, not many, or I don't know, sometimes we had many [laughs]. And I thought I would miss these hours with him, when we talked about all kinds of things, just the two of us. . . . He was more open and talkative when he was drunk and I liked that. (Marco, 30)

Marco also said he has a good relationship with his father today, although they do not drink together anymore: "I have never had problems with my dad. I have always admired him. . . . I am proud of him because he has managed to keep up his shop even in harsh economic times." To the question as to whether his father's alcoholism had any negative consequences for the

family's life, Marco answered: "My sister wouldn't agree but I don't have much negative to say about it. He was good at looking after us and we had all the things we needed."

If we look at the group of interviewees who primarily regarded alcoholism as socially conditioned, there are certain things that set them apart from the other participants in the study. First, they described their parents' drinking in more positive terms than the interviewees in the two other groups. Although most of the parents in this category, just like those in the other categories, seem to have or have had serious alcohol problems (all but one were described as "addicted" or "dependent") their children tended to normalize their drinking by saying that they "drank like their friends or colleagues" or like everybody else did back then in the 1980s and 1990s, or in other interviews: 1960s and 1970s. And although the parents' drinking had often had negative consequences (several had died from alcohol-related diseases, some had been fired or gone bankrupt, many had been divorced because of their drinking) their children tended to point at positive aspects as well, regarding alcoholism as only *one* dimension of their parents' lives. This is not to say that the interviewees in this group had not suffered from their parents' alcohol problems. Just like the participants in the two other groups, most of them mentioned negative things about growing up with an alcoholic parent: insecurity, distrust, never being able to count on one's parents, being left alone home when their parents were out drinking, shame, economic problems, and so on.

Second, it is within the group of people who regarded alcoholism as socially conditioned that we find the handful of interviewees in the study who said they drink, or previously have drunk, "too much" themselves. Some had started to drink early and said they had a "wild youth" with intense partying and heavy weekend drinking, which they left behind them in their mid or late 20s. Others had been at workplaces where it used to be "normal" to drink during working hours, but had later moved to other workplaces (such as their present one) where drinking was not allowed. Characteristic of many interviewees in this group is that they regarded alcoholism and addiction as relative phenomena and as conditions one can move in and out of. This in contrast to the interviewees in especially the first group (the disease model) who defined alcoholism as both absolute and as a chronic condition: you either are or are not addicted, and once you have become addicted you cannot return to "normal" drinking.

Discussion

As may be seen from the sections above, there is a pattern in the interviews tying the participants' understandings of their parents' alcoholism to the ways

they perceived their relationship to them. Participants who regarded alcoholism as the consequence of deliberate choices were the ones who described their drinking parents in the most negative terms. They felt their parents had deserted their family and chosen alcohol instead of their children and therefore (often) said that they now wanted nothing to do with them. Participants who regarded alcoholism as a disease often expressed ambivalent feelings toward their parents. They said that alcoholics cannot be blamed for their drinking because they have “lost control” over their lives and cannot help doing what they do. At the same time, some interviewees in this group felt they had been “used” by their parents and that they had to shoulder responsibilities they could not bear from an early age. Finally, participants who regarded alcoholism as socially conditioned were the ones who seemed most understanding and accepting of their parents’ drinking. They not only talked about negative experiences related to their alcoholic parents but also mentioned other, positive, things about them.

When comparing the three groups, we see that the social model of alcoholism constructs the drinker as most “normal,” and as someone the interviewees can identify with. The two other models depict a difference between the interviewees and their parents, either by defining the drinking parents as “sick”, that is, people the interviewees may pity, worry about, and seek to help, or by defining them as “bad”, that is, people the interviewees may blame and dissociate from.

Of the three groups of interviewees, participants in the “volitional,” and especially the “disease group,” are most reminiscent of children of alcoholics described in international research (e.g., Harter, 2000; Kroll, 2004). They related experiences of denial and secrecy, neglect, and feelings of having been let down more often than participants in the “social group,” and some of them focused on specific roles that children of alcoholics have to take on. For instance, interviewees in the disease group described themselves as being “overly responsible” from an early age, as being “protective” in relation to their parents, as being treated as “scapegoats,” and as acting as “go-betweens” in family conflicts. These descriptions may be compared with “coping roles” among children of alcoholics, identified in previous research (Black, 1979; Devine & Braithwaite, 1993; Potter & Williams, 1991). With one exception, such roles were not mentioned by participants in the group defining alcoholism as a socially conditioned phenomenon.

An intriguing question is how the mechanisms tying alcoholism models to depictions of childhood experiences work. Do differences in drinking problems (type and severity of alcoholism) and parent–child relationships lead to differences in understandings of alcoholism, and/or do specific understandings of alcoholism come together with specific ways of depicting childhoods

and parent–child relationships? There is much to indicate that the mechanisms work both ways.

There is *some* information in the interviews indicating differences in problem severity. For instance, most of the interviewees (but not all) who talked about physical violence and “psychological abuse” were found in the first and, especially, the second group. Also, contacts with addiction treatment and with AA/Al-anon were more common in the disease group than in the social group and the volitional group, and the respondents in the disease group more often used the term *control-loss* when describing their parents’ problems.

On the other hand, seven out of eight participants in the social group described their parents as “dependent” or “addicted” (and not just as “heavy drinkers”) and their accounts too contained examples of parental neglect and/or humiliating behaviors. For instance, interviewees in the social group told about parents “bullying” and “chasing” them when drunk (expressions in interviews), single parents leaving their children to look after themselves while moving in with a new partner, and parents letting their children and grandchildren down by not keeping appointments, for example, birthdays or Christmas parties, weekend trips, and so on.

Also, there were no systematic differences in the information about alcohol-related illness or parental death between the three groups; early death of a heavily drinking parent was as common in the social group as in the two other groups. Nor were there differences in parental divorces; about half of the parents had (according to the interviewees) had a divorce due to alcohol problems, but the divorces were evenly distributed over the three groups. With regard to socioeconomic status (in childhood families and among ACOAs at the time of the interview), the differences were small as well. There was a weak tendency, though: the social model was somewhat more common in working-class families and among interviewees with short training (five out of eight participants in the social group had only primary school education or basic school education followed by short vocational training), whereas the voluntary group contained relatively many academics (four out of six participants).

Childhood experiences seem to lead to specific understandings of alcoholism, just like understandings of alcoholism seem to lead to specific interpretations of childhood experiences. Parents in the disease group may indeed have “lost control” over their drinking more completely than parents in the social group. This loss-of-control probably brought them into contact with the treatment system and may also have led their children to assume specific roles (the responsible child, the go-between, etc.) and to seek help in Al-Anon as grown-ups. An alternative, or supplementary, interpretation is that the families’ contacts with the treatment system, and ACOAs’ contacts with Al-Anon,

have led the interviewees to regard their parents as “sick” (and not as “bad” or “normal”), to focus on their “control-loss,” and to retrospectively conceptualize their own behavior in terms of “coping roles.”

In a similar way, parents in the volitional group may have made “bad choices,” prioritizing their own interests over their children’s needs, abusing and hurting them, with the result that their offspring now want nothing to do with them. An alternative interpretation is that participants in the voluntary group, for some reason or other, understand people’s behavior as resulting from deliberate choices, and that it is this view of human nature, rather than the explicit behaviors of their parents, that makes them feel especially hurt and let down. This interpretation is supported by the fact that the interviewees in this group also ascribed their own behavior (their own drinking habits as well as their general lifestyle and relationships to other people) to deliberate decisions, “will-power,” and “back-bone.”

Parents in the social group, finally, may have had drinking patterns that were reminiscent of the drinking patterns of their colleagues and friends, and therefore more “normal” than the drinking patterns in the two other groups. However, here as well, the mechanisms may also have worked the other way. The social model of alcoholism, probably a model the interviewees were socialized into from an early age, may have lead them to focus on certain aspects of their parents’ behavior (e.g., their attempts to provide care and protection) and to ignore others. As mentioned above, some of the interviewees in this group said they were drinking, or had been drinking, “too much” themselves. For these interviewees, the positive assessments toward their drinking parents—“you are not necessarily a bad parent because you drink too much” (quote from interview)—may be part of a tendency to normalize/legitimize heavy drinking, their own heavy drinking included.

The discussion of the relationship between childhood experiences and conceptions of alcoholism should not be read as a questioning of the “truth” of the interviewees’ accounts. As pointed out by Burk and Sher (1988), the prevailing view in much of the clinical literature on children of alcoholics is that they are affected negatively by their parents’ drinking, regardless of what they are saying themselves and even in cases where they appear well-adjusted. Seen from this perspective, the interviewees’ accounts about parent–child relationship could be read as “biased” in accordance with a specific (mis)understanding of the nature of alcoholism. The perspective of the present article is different. From a narrative point of view, there are no “true” experiences in the past that can be captured independently of the perspective of the present (Mead, 1959). We, as researchers, can never get back to our interviewees’ “raw biographical experience” (Denzin, 1990, p. 12). All we have are stories about experiences, and stories are always told at a specific moment and from

a specific perspective (Järvinen, 2004). The past “in itself” is not a past that can be analyzed in life histories; the past only exists in relation to a human present possessing the power of interpretation (Mead, 1959; Ricoeur, 1984).

Finally, the limitations of the study should be mentioned. First, it is important to note that the sample was recruited from a specific workplace and not from the population at large. Although the employees at the workplace represented a wide range of socioeconomic backgrounds and age-groups, some parts of the population (and hence, some groups of ACOAs) are not covered: people under 18 and over 65, unemployed people, people on sick-leave or early retirement, and so on. Because of the delimitation of the study group to people in employment, some of the ACOAs who have suffered the most from childhood neglect and abuse may have been excluded from the study (e.g., marginalized groups with substance use problems and people with mental health problems). Second, the question used to identify ACOAs in the survey focused on the parents’ drinking patterns when the respondents were 15 years old. This probably excluded some ACOAs whose parents’ drinking problems had either diminished or had not yet developed into addiction when the respondents were teenagers, meaning that some ACOAs with lighter parental problems may have been left out. Third, only ACOAs who in the survey wrote that they were willing to participate in a subsequent qualitative study were contacted for interviews. We cannot know if respondents who did not want to be interviewed looked on alcoholism in different ways from those interviewed, or if their childhoods were more or less affected by their parents’ drinking problems than the interviewees were.

This study then, was an exploratory study without ambitions to generalize its findings to adult children of alcoholics in general. The study showed how differently childhoods with alcoholic parents may be experienced, and identified patterns tying understandings of alcoholism to specific depictions of parent–child relationships. Hopefully, these findings may inspire other researchers in the field, quantitative as well as qualitative, to focus on conceptualizations of addiction among children of alcoholics and on the relationship between these conceptualizations and childhood recollections.

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Notes

1. The survey focused on drinking patterns (frequency and intensity of drinking, attitudes to drinking, conceptions of risks related to drinking, etc.), stress, health behavior, and so on, among the employees. Some of the questions concerned the respondents' childhood, including the drinking patterns of their parents.
2. Another question in the survey focused on the parents' alcohol consumption on "festive occasions"—this question too contained the answering alternative "they had problems related to alcohol."

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